

New Jersey Department of Health and Senior Services
Office of Emergency Medical Services
PO Box 360
Trenton, NJ 08625-0360
609-633-7777 609-633-7839 (Fax)
VEHICLE ACCIDENT REPORT

Check One:

- ☐ MAV
☐ SCTU
☐ BLS Ambulance
☐ MICU

In accordance with N.J.A.C. 8:40-3.7, agencies are required to notify the Office of Emergency Medical Services within fourteen (14) days of an accident. Complete this form and submit with documentation to the Office of Emergency Medical Services at the address provided above.

PROVIDER INFORMATION		
Name of Agency	Date Report Filed / /	
Address of Agency		
Name of Person Filing Report	Title	
DETAILS OF ACCIDENT		
Date of Accident / /	Time of Accident	Location of Accident
<u>Type of Accident</u> <input type="checkbox"/> Head-On <input type="checkbox"/> Rear-end <input type="checkbox"/> Broadside <input type="checkbox"/> Roll-over <input type="checkbox"/> Pedestrian Struck <input type="checkbox"/> Vehicle vs. object <input type="checkbox"/> Other: _____		
<u>Vehicle Location</u> <input type="checkbox"/> Roadway <input type="checkbox"/> Parked <input type="checkbox"/> Intersection <input type="checkbox"/> Other: _____		
<u>Status at time of Accident</u> <input type="checkbox"/> Responding to 911 call <input type="checkbox"/> Non-Emergency Transport <input type="checkbox"/> On Scene <input type="checkbox"/> Enroute to medical facility with patient <input type="checkbox"/> Enroute to medical facility without patient <input type="checkbox"/> Responding for Non-Emergency Transport <input type="checkbox"/> Not on Assignment <input type="checkbox"/> Other: _____		
VEHICLE INFORMATION		
Vehicle Number	License Plate Number	VIN Number
Vehicle Out of Service? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain: _____		
<u>At Time of Accident</u> <input type="checkbox"/> Emergency Lights On? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Siren On? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>Use of Seatbelts</u> <input type="checkbox"/> Driver: <input type="checkbox"/> Yes <input type="checkbox"/> No EMT Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> MICU Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Passengers: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain: _____		
SUMMARY OF ACCIDENT		
<u>Attach the Required Documents:</u> Police Report: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain: _____		
<u>For Accidents with Injuries: Submit EMS Incident Report, Patient Care Report and Police Report TOGETHER when received.</u> <input type="checkbox"/> Injured Patient(s): <input type="checkbox"/> Yes <input type="checkbox"/> No Injured Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No		